MANUAL FOR STATE MEDICAID AGENCY MONITORING OF PSROs

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH CARE FINANCING ADMINISTRATION

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The Manual for State Medicaid Agency Monitoring of PSROs sets forth several approaches State Medicaid agencies may wish to use as States develop monitoring programs to determine what effect PSRO review is having on the quality and utilization of care delivered to Title XIX patients. This Manual has been revised following the receipt of State and PSRO comments on an earlier draft edition. These generic approaches are not the only ones States might use in developing a PSRO monitoring system. These are suggested approaches and the successful implementation of one or a combination of the monitoring approaches will ultimately depend upon the interest and capabilities of each State.

As stated in SRS-AT-76-140 issued on September 3, 1976, monitoring of PSROs by States is not a required activity. However, the Health Care Financing Administration encourages States to perform monitoring thereby assisting the Department in the overall assessment of PSRO impact. Federal financial participation is available for State monitoring activities conducted under an approved monitoring plan. The procedures States should follow in submitting monitoring plans as well as the elements to be included in such plans are described in the issuances appended to the Manual.

H.R. 3 and S.143 pending legislation include provisions to strengthen PSRO/State relationships in such areas as monitoring. While this Manual is largely intended for State Medicaid agencies to use in implementing their plans for PSRO monitoring, PSROs should be familiar with the generic models. In addition, PSROs should understand their responsibility to comment on plans submitted by States and to work cooperatively with States as the latter perform monitoring activities under a DHEW approved monitoring plan. Monitoring is one aspect of strengthening PSRO/State cooperation and this Manual furthers such a concept.

The Medicaid Bureau and the Health Standards and Quality Bureau will keep you apprised should it become necessary to change any of the substantive material in the Manual, or any of the procedures States should follow in submitting monitoring plans.

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MANUAL FOR STATE MEDICAID AGENCY MONITORING OF PSROs

developed under the project to
Design Methodologies and Guidelines for
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Review of Medicaid (Title XIX) Programs

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1.0 INTRODUCTION AND PURPOSE

The Act which created the Professional Standards Review Organization (PSRO) program was the Social Security Act Amendment of 1972 (Public Law 92-603). Title 11, Part B, §1151 states as its purpose "to promote the effective, efficient, and economical delivery of health care services of proper quality" for which payment is made under the Social Security Act (the Act). Section 1155 of the Act goes on further to stipulate that services delivered must conform to appropriate professional standards for provision of health care, and that payment will be made under the Act only to the extent that services are determined to be medically necessary and appropriately delivered in a hospital or other health care facility, organization, or agency in accordance with professionally recognized health care standards. The initial charter of the PSRO program includes review of admissions of patients receiving benefits under the Medicare, Medicaid, and Maternal and Child Health programs (Titles XVIII, XIX, V of the Act) in acute care hospitals.

The Secretary of the Department of Health, Education, and Welfare (DHEW) was given the responsibility by Congress of implementing the provisions of this Act. The implementation process has involved designation of 203 PSRO areas nationwide, and conditional designation of more than 100 PSROs which have initiated, or are in the process of initiating, concurrent review activities. This conditional period, originally expected to be two years in duration, is intended to provide an assessment of PSRO performance while the PSRO implements review according to its formal plan.

These conditionally designated PSROs have been authorized by the Act to make determinations concerning the medical necessity and quality of services delivered to Title V, XVIII, and XIX recipients. Section 1164 of the Act (Title XI, Part B) makes the Act's provisions applicable to State plans. A subsequent interpretation made by the Secretary in February 1975, was that conditional PSROs,

if found competent, would exercise final authority on issues of medical necessity and quality of care for purposes of claims payment for the Medicaid program. [SRS-AT-75-42(MSA)]. The impact of this determination on State Medicaid agencies is that PSRO review decisions are binding on the States and that existing utilization review systems will be superseded by PSRO review. In other words, claims for services included in the State plan that originate in hospitals under PSRO review must be paid by the State Title XIX agency (or its delegated agents) to the extent authorized by the PSRO, regardless of whether they would have been passed by the State's own utilization review system. Consequently, PSRO binding review replaces State utilization review requirements, including prior authorization of services for which the PSRO has assumed review responsibility.

Further clarification of this policy can be found in SRS-AT-76-140 which was sent to the States in September 1976. This document defines State involvement in PSRO implementation, explains the role of States in monitoring PSRO activity, and presents complaint system procedures States may utilize to seek resolution of problems identified in their monitoring of PSRO review decisions. DHEW policy strongly urging that States monitor PSROs is clearly presented in this Action Transmittal. States are requested to assist the Department assure the integrity and effectiveness of PSRO performance through the States' monitoring efforts. It is stated that State expenditures for a variety of monitoring activities will be matched by DHEW provided that the States' activities do not duplicate the purposes of PSRO review or serve to override PSRO decisions as to medical necessity.

As the PSRO program has begun to mature and PSRO review has been initiated, some States have expressed a concern that having a non-State agency (PSRO) make medical necessity decisions may pose a threat to the fiscal integrity of their Medicaid programs. These concerns have been expressed most strongly

by States with the larger Medicaid programs, many of which have laboriously developed their own utilization review systems to control program costs.

Costs of the Medicaid program is of concern to the Federal government as well as to the States. Both parties share a common interest in ensuring that health services provided under Title XIX programs are appropriate to the needs of recipients. It is with both of these concerns in mind that the 1972 Amendments to the Social Security Act included procedures for professional standards review. These procedures stipulate that it is the responsibility of PSROs to determine that services rendered are medically necessary and are provided in accordance with professional standards of care. It is desirable, therefore, for States to be able to monitor the performance of PSROs within their boundaries so that they can effectively determine what impact PSRO review has had on utilization of services and resulting State expenditures. Prior to initiating monitoring activities, States are required to submit their monitoring plans for approval.

The purpose of these draft methodologies and guidelines (referred to herein as protocols) is to propose a framework for use by State Medicaid agencies developing their plans for setting up a monitoring system. Because each State's Medicaid program is different, particularly in terms of the types of data available for monitoring, it has not been possible to define in detail a single PSRO monitoring system. Instead, the protocols have taken the form of general suggestions for program monitoring with the idea that each State will use these suggestions in constructing a PSRO monitoring system that suits its particular needs and is feasible in terms of its overall resources. An attempt has been made by presenting these protocols to define several "generic" approaches to monitoring PSRO performance and to discuss some of the implications of each approach in terms of comprehensiveness, procedures, data requirements and resource needs. These generic "models" represent an effort on the part of the Medical Services Administration

(MSA) and Bureau of Quality Assurance (BQA)[1] to generalize from the monitoring program already in operation in a few States that appear to span the range of Medicaid program characteristics. States having a Medicaid Management Information System (MMIS) should be encouraged to develop a monitoring approach which is coordinated with the data outputs from that system. It is recognized, however, that each State will have to tailor these approaches to meet its particular needs, and will have to spend some time in setting up the operational details required to actually implement a monitoring program.

It must be emphasized that these monitoring approaches are being proposed to States for their consideration. States are not required to adopt and implement these monitoring approaches. Rather, this document is intended to provide guidelines to States which might be useful to them as they develop their monitoring plans. States are encouraged to develop their own approaches to monitoring in accordance with the specifications of SRS AT 76-140.

In summary, this manual is intended to present several approaches for States to consider as they prepare monitoring plans. The manual is designed to offer potential methodologies for legitimate monitoring activities. The manual is not intended to discuss State/PSRO relationships in their entirety. States and PSROs should review SRS AT 76-140 and 76-141, MSA AT 77-43, and BQA General Memorandum 15-77 for a more thorough discussion on such relationships. In addition, these issuances describe the process States should follow in submitting their monitoring plans to the Department, and the responsibility PSROs and hospitals have in reviewing such monitoring plans before they are implemented. These documents are included as appendices to this manual.

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[1] As of March 8, 1977 MSA and BQA are two components of the Health Care Financing Administration. Herein, they will be referenced by their new names, Medicaid Bureau and Health Standards and Quality Bureau (HSQB), respectively.

2.0 SOME GENERAL CONSIDERATIONS IN PSRO PERFORMANCE MONITORING

DHEW strongly supports the implementation of PSRO review as the mechanism to control unnecessary health care utilization and improve the quality of health care provided Medicaid patients. PSROs and State Medicaid agencies are strongly encouraged to work together closely to achieve these objectives [SRS-AT-76-141(MSA)].

It is recognized by DHEW that a long lead time is required before PSRO review can be fully implemented. During the conditional period of PSRO review, State Medicaid agencies have the opportunity to monitor the review activities of PSROs which fall within their purview. Objectives of States in this monitoring effort include the following:

- Determine if PSRO review is being carried out appropriately
- Ensure that State and Federal funds for institutional health care are being appropriately spent for necessary and quality care
- Identify areas of concern which should be addressed by the PSROs, States, and/or DHEW
- Determine whether PSRO review has affected utilization of services and expenditures of funds either positively or negatively
- Determine if PSRO review is effective.

These objectives can be achieved through several different approaches which will be individually discussed in the remainder of this document. Before presenting the specifics of these approaches to PSRO performance monitoring, however, a few general points should be made regarding the overall "philosophy" of any monitoring system. These points should be kept in mind as the details of a system are worked out.

A. The monitoring system should focus on results.

The main concern of the State is to ensure that the PSRO is effectively controlling utilization of services, not to oversee procedures being used by the PSRO to do its review. The monitoring system should focus on key utilization indicators like admissions, length of stay and total days of stay per thousand. If the monitoring system shows that these performance measures are meeting previously defined standards it is not necessary to look further. The only time when further investigation of the actual process of review is indicated is when the results are out of line with the standards. Such an "exception based" concept will minimize the costs of doing the monitoring, will ensure that the impact on program costs is able to be determined, and will improve PSRO review activities.

B. The monitoring process should be objective.

To the maximum extent possible, the State should rely on written criteria for evaluating PSRO performance, and minimize the role of subjective, individual assessment that can vary from person to person and from time to time. This will ensure smooth relationships with the PSROs, who will know in advance the criteria against which they are being evaluated, and that they are being judged consistently. It will also minimize the likelihood of unresolvable disputes with PSROs, and will ensure that information is clear and unambiguous. It is recognized, of course, that some subjective components may be required — medical judgment, for example — but the guiding philosophy should be to remain objective whenever possible.

C. The monitoring system should, to the maximum extent possible, be built upon or integrated with existing mechanisms in the State Medicaid program.

Every State is very likely already carrying out a number of activities that can usefully be integrated into a performance monitoring system. Such activities could include claims review (manual or automated), physician consultant

referral networks, utilization analysis and monitoring, claims investigation, and a variety of others. By taking advantage of the functions already being performed in these areas, the monitoring system can be more smoothly integrated into the existing organization and can be conducted at lower incremental cost than if it is developed and implemented as a completely separate activity.

D. The monitoring system should be completely designed and accepted prior to implementation.

Prior to initiation of monitoring activities, State Medicaid agencies are required to submit for approval a detailed description of their monitoring plans. The plans should be accompanied by comments from those PSROs whose performance will be monitored and from hospitals impacted by this effort [SRS-AT-76-140(MSA].

The Memorandum of Understanding (MOU) which is signed between a State and its PSRO(s) should indicate whether State monitoring of PSRO activity will occur. However, the MOU signed by a PSRO and its State agency does not uniformly provide specific information in regard to the State monitoring plan. The Health Standards and Quality Bureau has recommended that the agreements contain only a reference to the monitoring plan. All specifications should be provided in the plan itself, which, following DHEW approval, will be attached as an appendix to the MOU. For a monitoring approach to be effective in achieving specified objectives, States and PSROs must work closely together. It can be expected that if cooperative relationships have been established, any problems which are identified will be readily resolved.

3.0 MODEL APPROACHES TO MONITORING PSRO PERFORMANCE

3.1 INTRODUCTION

After examining the kinds of data and system available for monitoring PSROs in a variety of States, and after looking at some exemplary approaches to monitoring developed by a few States who seem representative of the universe of Medicaid programs, the following generic approaches have been selected for presentation:

1. A monitoring system based solely on data collected by the PSROs themselves and reported to HSQB through the PSRO Management Information System.
2. An approach based on retrospective, postpayment review of claims submitted to the State for payment of services rendered to Title XIX recipients.
    a. A system based on randomly selected sample of claims submitted to the State. This review of a sample of claims can be performed by the State agency or the State's fiscal agent.
    b. A system based on automated screening of all claims from PSRO areas. This approach is the most comprehensive and may be the least expensive, but it requires the State to have an automated claims processing system with built-in screens.

Again, it is stressed that these models are intended only as general guidelines, not as mandatory approaches or detailed recommendations. Each State will have the opportunity to adapt some or all of these approaches to its specific needs and capabilities.

3.2 PROTOCOL BASED ON PSRO MANAGEMENT INFORMATION SYSTEM DATA

3.2.1 Concept

For States with interest in analyzing data produced by a system external to their own operations, the PSRO Management Information System (PMIS) could produce summary reports on PSRO activity within each State. Examples of types of reports which could be produced and presentation of their possible uses will follow an overview of the PMIS and its components.

3.2.2 Definition and Purpose of PMIS

The PMIS is the focal point through which data are collected, processes analyzed and reported back to managers responsible for PSRO related activities. This system provides information about the PSRO program to persons responsible for its operation, coordination, management, and evaluation. The PMIS is intended to provide the necessary management feedback to the local PSROs in addition to meeting the data requirements of DHEW, the National Professional Standards Review Council, States, and other Federal agencies, and Congress.

The purposes of the Federal reporting requirements are:

- To fulfill the intent of Section 1155 (i)(1)(B) of P.L. 92-603, the 1972 amendments to the Social Security Act, which mandates DHEW to establish Federal reporting requirements for the PSRO program
- To provide that set of information which will both assist each PSRO to monitor and assess its activities at the local level and allow the Federal and State governments to meet their monitoring responsibilities

- To build a data base for preparing reports which compare the extent and type of review activities and expenditures among PSROs with similar characteristics
- To allow the Federal government to obtain summary information on PSRO activities and costs which will contribute to contract renewal decisions.

The data derived from the PMIS is meant to fulfill specific needs at the various levels of the PSRO program:

- At the PSROs the PMIS will assist in:
  - Managing review activities in nondelegated hospitals;
  - Monitoring review activities and service utilization in all hospitals;
  - Documenting efforts made to improve the medical care delivered in the PSRO area;
  - Managing current operations and planning for future needs; and
  - Satisfying contract or agreement negotiation and renewal requirements.
- PMIS will assist HSQB and DHEW Regional Offices in:
  - Monitoring PSRO activities;
  - Monitoring hospital service utilization and review cost trends and activities;
  - Administering the national program;
  - Expediting the contract or agreement renewal process.
- PMIS will assist State Medicaid agencies in:
  - Monitoring PSRO implementation in hospitals;
  - Monitoring hospital service utilization and cost trends;

— Comparing activities and utilization trends on a Statewide basis, as well as on an individual PSRO and related hospital basis.

3.2.3 Components of the PMIS

The PMIS is made up of several key subsystems which when considered collectively form an integrated input/output system which continually develops with the evolution of the PSRO program.

The key elements of the system are:

- Federal Reports Manual (FRM)
- Contracts Management Manual (CMM)

The Federal Reports Manual is made up of four areas of reporting requirements which may be helpful to States:

- Concurrent review activity — data on the volume of admission certifications, continued stay review, physician advisor involvement in certification and continued stay decisions, length of stay and certified days approved and utilized.
- Medical Care Evaluation (MCE) study reporting — data on the number and types of MCE studies being performed, and the status and outcome of these studies.
- Cost Reporting - data on PSRO and delegated hospital costs by function and expenditures category.
- PSRO Hospital Discharge Data Set (PHDDS) Reporting — data on all Federal patients reviewed by the PSRO and their delegated hospitals.

The Contract Management Manual subsystem provides baseline data on characteristics of the PSRO area, PSRO membership status, and descriptions of plans for training, data systems, and review activities.

The monitoring system which will be presented below contains information derived solely from the Federal Reports Manual, concurrent review activity reports and PHDDS reporting from PSROs.

3.2.4 General Approach to Design and Use of PMIS Reports

The principal purpose in developing report formats for use by State Medicaid agencies is to establish a systematic communication link between PSROs, HSQB, and State Medicaid agencies. The proposed reports presented below would provide summary information to persons responsible for monitoring PSRO activities. The suggested data elements would provide aggregate information about Title XIX recipients who have received inpatient services during the reporting period. The level of aggregation presented would be dependent on the type of information available to the group or organization responsible for producing the reports. For example, for a State Medicaid agency to receive a summary of review activity for all PSROs within the State, the Health Standards and Quality Bureau would be the only source of the data (except in the case of single-State PSROs, where the PSRO could provide them).

The individual PSROs or HSQB would be able to provide summary information about discharges reviewed by delegation status of the PSRO's hospitals and information about days of stay. The reports, samples of which are presented below, would provide the following types of aggregate information to State Medicaid agencies:

- Degree of PSRO implementation in its area hospitals by delegation status
- Number of Title XIX discharges reviewed during the reporting period

- Number of days of stay
  - Total number of days certified
  - Total number of certified days used
  - Total days of stay
- Average length of stay

As was discussed above, it is envisioned that these reports will be produced on the following three levels for State Medicaid agencies' use:

- Statewide summary of activity for all PSROs within the State (Exhibit 1)
- Individual PSRO summary of activity by delegation status (Exhibit 2)
- Individual hospital summary activity by PSRO area (Exhibit 3)

It should be emphasized that these are samples of output which are available through various components of the PMIS reporting system. Data shown in the sample exhibits and in all exhibits in this manual are not intended to represent activities in any existing PSRO.

Since these Statewide reports would have to be produced by either the States' PSROs or HSQB, standard report formats will have to be developed for use by State Medicaid agencies. Whatever reports State Medicaid agencies and HSQB agree should be produced, there are certain key issues which must be kept in mind concerning the inherent limitations for use of these data. These issues include the following:

- The data presented will be aggregate figures concerning numbers of discharges, days of stay and average length of stay. As such, they are gross indicators about activity within PSROs and their hospitals.

- Aggregate data can only show where differences exist between activities of individual PSROs and their hospitals as compared to one another.
- Aggregate data can only be used as a basis for formulating questions concerning these differences. They can not answer questions as to what the differences mean, whether they are significant, or why they occurred.
- PSROs do not have the data to relate the number of inpatient days utilized by Title XIX recipients to the costs of providing these services as paid through the State Medicaid program. If State Medicaid agencies make an attempt to relate PSRO utilization data to their own cost data, the State agency must be cautioned to guard against comparison of dissimilar data, in terms of timeframe of the reports, recipient specific charge data versus aggregate utilization information, and data from partially implemented PSROs.

These types of reports could be useful to State Medicaid agencies to give agency staff an overview of what is happening in their State or in a given PSRO. The points presented above, however, outline some of the limitations in use of these data. If these reports are produced for State Medicaid agencies, they would be most appropriately utilized in conjunction with reports produced through one of the other systems presently in this manual. If other, more detailed reports are not available to State Medicaid staff, these reports can provide a framework for analyzing trends.

While each State will have to tailor these types of reports to its own needs, and work out the details of its own system, Exhibits 1, 2, and 3 illustrate the types of reports which could be produced through the PMIS.

Exhibit 1 illustrates a quarterly Statewide summary report to be prepared by HSQB. This report provides an overview of all PSRO activity within the State. It focuses on three major variables, namely, degree of implementation of hospitals, number of Title XIX discharges, and days of stay. From this report the State could compare the relative activity of PSROs within the State and relate these variables to see if further analysis is required.

In the example, while the number of hospitals in each PSRO area, the degree to which review activity has been implemented, and the number of discharges reviewed differ, the average length of stay for each appears not to be significantly different. In three of the four PSRO areas, the average length of stay for this quarter is higher than for the Fiscal Year (FY) to date, a fact which may warrant further analysis. Depending on the type of detailed information which is available from other sources, the State agency could determine the significance of these data.

Exhibit 2 is an example of a quarterly report prepared by either the PSRO or HSQB which summarizes an individual PSRO's review activity displayed according to the delegation status of its hospitals. This report is a subset of the Statewide summary (Exhibit 1) and provides more detail on the PSRO's activity. In Exhibit 1 it was noted that XYZ Foundation for Medical Care's average length of stay had gone up in the most recent quarter. Exhibit 2 shows that the same PSRO has delegated 60 percent of its hospitals and that these hospitals account for nearly 70 percent of the PSRO's Title XIX discharges, and 75 percent of the total days of stay. It can also be observed that the average length of stay is 6.31 days for Title XIX discharges reviewed in delegated hospitals and 5.01 and 4.15 days in nondelegated and partially delegated hospitals respectively. Without testing for statistical significance, the State Medicaid agency would know that delegated hospitals are different from the other two types. This difference may be attributed to many factors including the following:

Statewide PSRO Concurrent Review Summary for Title XIX Discharges

Prepared by HSQB

Quarter Ending: December 31, 1976

PSROs Reporting Title XIX Discharges

ABC PSRO
ADF Medical Care Foundation
DBR Health Care Review Organization
XYZ Foundation for Medical Care

PSRO Name	#Hosp. in PSRO Area	Actual #Hosp. under Review	Hosp. under Review as % Total Hosp. by Del. Status Non	Full	Part	%Hosp. not under Review	Total Title XIX Disch.	Certified Days of Stay Total	Certified Days of Stay Total Used	Total Days of Stay	Average Length of Stay
(1)	(2)	(3)	(4)			(5)	(6)	(7)	(8)	(9)	(10)
ABC PSRO											
This qtr	23	4	8	8	0	84	8,450	47,260	43,890	44,954	5.32
FY to Date							18,720	99,740	96,222	96,595	5.16
ADF Med. Care Found.											
This qtr	10	7	20	30	20	30	26,943	168,401	164,210	165,385	6.13
FY to Date							54,724	339,760	340,501	341,478	6.24
DBR Health Care Rev. O.											
This qtr	6	6	0	100	0	0	10,625	75,461	66,938	66,938	6.30
FY to Date							22,467	145,230	128,520	129,704	5.77
XYZ Found. Med. Care											
This qtr	42	38	24	60	7	9	17,600	123,912	102,898	103,307	5.87
FY to Date							38,963	221,563	210,431	230,607	5.42
This Quarter Total	81	55				45	63,618	415,037	377,936	380,584	5.98

Exhibit 1

PSRO Concurrent Review Summary for Title XIX Discharges

Prepared by PSRO or HSQB

Quarter Ending: December 31, 1976
PSRO Name: XYZ Foundation for Medical Care

Delegation Status	Hosp. under Review as % of Total Hosp.	Total Title XIX Disch.	Title XIX Patients Granted Adm. Cert.	Title XIX Patients Reviewed for Cont. Stay	Certified Days of Stay		Total Days of Stay	Average Lgth of Stay
					Total	Total Used		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
PSRO Review Non-Delegation (10)	24	4,675	4,625	2,815	27,934	23,225	23,362	5.01
Hospital Review Delegated (25)	60	12,190	12,140	6,706	92,156	76,758	76,970	6.31
Partially Delegated (3)	7	735	726	299	3,822	2,915	2,975	4.05
TOTALS	91	17,600	17,492	9,820	123,912	102,898	103,307	5.87

Exhibit 2

- The delegated hospitals could include among them university teaching hospitals where lengths of stay are traditionally longer than in community hospitals.
- These hospitals could be highly specialized institutions whose proportionate share of seriously ill patients (ones whose length of stay would be expected to exceed norms for the area) is greater than other area hospitals.
- The fact that they are delegated may significantly impact the average length of stay if the PSRO is not training their staff or monitoring their activities in the same manner as they do for the nondelegated and partially delegated hospitals.

Other variables may also be important factors which would be able to explain these differences. The major point is that from this report alone, the State Medicaid agency will not be able to determine why these differences exist, but will be provided a basis for formulating further questions.

Exhibit 3 is a quarterly concurrent review summary for all hospitals within a single PSRO. This report could only be prepared by the individual PSRO and/or its data processor since only they have hospital specific data. It should be noted that this report is also a subset of that shown as Exhibit 1. ADF Foundation for Medical Care is shown to have the greatest number of Title XIX discharges with a relatively small number of hospitals in its area. On Exhibit 1 its average length of stay is shown to be higher than the Statewide average (again, statistical significance is not determined). On Exhibit 3 it can be noted that delegation status of the hospitals does not appear to have a significant impact on average length of stay. There are, however, four hospitals whose lengths of stay are responsible for the PSRO's greater than average overall length of stay.

PSRO Concurrent Review Summary for Title XIX Discharges
(Detailed Analysis)

Prepared by PSRO

Quarter Ending: December 31, 1976
PSRO Name: ADF Medical Care Foundation

Hospital Name	Delegation Status FD/ND/PD	Total Title XIX Disch.	Title XIX Patients Granted Adm. Cert.	Title XIX Patients Reviewed for Cont. Stay	Certified Days of Stay		Total Days of Stay	Average Length of Stay
					Total	Total Used		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
ABC Hosp.	ND	2,320	2,320	1,174	13,670	12,460	12,598	5.43
DEF Hosp.	PD	4,760	4,760	2,498	33,452	30,737	31,321	6.58
GHI Hosp.	FD	9,850	9,850	5,321	60,740	61,540	61,562	6.25
JKL Hosp.	FD	2,103	2,103	1,549	10,998	11,960	11,966	5.69
MNO Hosp.	FD	5,670	5,670	2,780	32,890	33,016	33,113	5.84
PQR Hosp.	ND	900	900	462	6,745	5,765	6,075	6.75
STU Hosp.	PD	1,340	1,340	740	9,908	8,732	8,750	6.53
TOTALS		26,943	26,943	14,524	168,404	164,210	165,385	6.13

Exhibit 3

No determination can be made from this report as to why these hospitals have longer average lengths of stay, but it would be appropriate for the State Medicaid agency to analyze the situation further.

After this preliminary review, it might be reasonable to hypothesize that GHI is a teaching hospital and/or inner city institution since it has reported the largest number of discharges. The 6.25 average length of stay could be considered reasonable if this figure is comparable to other similar institutions. The DEF hospital is more difficult to explain since it falls in the mid range of discharges reviewed and has no other distinguishing characteristics. Since the PSRO's two smallest hospitals (in terms of Title XIX discharges reviewed) have average lengths of stay which are longer than those of most of the other hospitals, further analysis of their individual situations may be warranted. PQR Hospital has a relatively small number of discharges and is a nondelegated hospital. It may be a newly implemented hospital and the PSRO may not have fully implemented all review procedures. This type of situation could account for patients who are not identified as Title patients to be reviewed, and as a result stay in the hospital longer than would be the case in a more experienced institution.

The situations presented above are merely hypothetical suppositions made to accomplish the following objectives:

- Demonstrate approaches to analyzing proposed PMIS based reports
- Illustrate ways in which differences in PSROs' or hospitals' performances may be further investigated
- Present reasonable explanation for these differences, or, in fact, highlight areas where problems actually exist
- Integrate information from three different reports on activities of individual PSROs as found on the following levels of aggregation:

- Statewide summary
- Individual PSRO summary
- Individual hospital summary

As answers to types of questions presented above are worked out between the State Medicaid agency and its PSROs, a clearer understanding of the methods, types of activites, problems encountered and expectations of all concerned parties could be anticipated to develop. HSQB and State Medicaid agencies working through Medicaid Bureau will develop the types of reports which will assist States in their efforts to monitor the performance of PSROs.

In addition to producing reports on concurrent review activity, HSQB is currently developing draft formats for PHDDS reports. These reports will include data, as reported by PSROs, on each Federal discharge reviewed by PSROs. Most of the conditional PSROs are in the early stages of implementation of their data systems which will produce PHDDS data. The data base, therefore, is not currently large enough in terms of number of Title discharges included or number of consecutive quarters of data reported by individual PSROs to make reports on PHDDS data meaningful. HSQB is currently testing a sample of the existing PHDDS data base in anticipation of producing a comprehensive set of PHDDS reports which will be available for use by State Medicaid agencies.

The proposed national level PHDDS output reports deal with diagnosis-specific data, and could be directed at key elective surgical procedures, if necessary, to demonstrate hospital utilization controls and their effectiveness. PHDDS output reports can also present key diagnoses which account for a majority of admissions and compare PSROs (e.g., tracer diagnoses). The types of reports which might be of interest to State Medicaid agencies and are being considered for inclusion in PHDDS quarterly report package are the following:

- Utilization of days of care distributed by selected diagnostic groups with detailed information for each group being:
  - Number of discharges
  - Number of deaths
  - Total days of stay
  - Average length of stay for live discharges
  - Average pre-op stay
- Comparison by diagnostic group the median stay reported by an individual PSRO against all other PSROs in its Federal Region
- Ranking of leading causes of admission by number of discharges in an individual PSRO and within its Federal Region
- Ranking of leading causes of admission by days of care in an individual PSRO and within its Federal Region
- Utilization by selected procedures with detailed information for each procedure being:
  - Number of discharges
  - Number of deaths
  - Total days
  - Average stay for live discharges
  - Average pre-op stay
- Average pre-op stay for selected procedures by individual PSRO and within its Federal Region

The proposed reports mentioned above are being considered by HSQB as an initial effort at producing PHDDS output reports. It is anticipated that, where applicable, data could be aggregated nationally, by Federal Region, and by individual PSRO for these types of reports. Statewide aggregation of the data could be considered by HSQB if interest in the reports is expressed by State Medicaid agencies which have more than one PSRO within their boundaries. Decisions

have not been finalized on report content, production priorities, or report periodicity by HSQB. Outcomes of the tests on the sample PHDDS data as well as input from PSROs, Regional PSRO staff, States, and other Federal agencies will be utilized to finalize the initial report sets. As additional data needs of users become identified, the HSQB data processing and report production systems are flexible and will accommodate these needs.

3.3 PROTOCOL BASED ON DATA GATHERED THROUGH CLAIMS REVIEW PROCESS

3.3.1 Concept

In addition to, or as an alternative to use of PMIS generated data, State agencies may choose to monitor PSRO performance through existing systems of postpayment claims review. Since the specific characteristics of these systems differ from State to State, this manual will present two generic models, namely:

- Retrospective review of a sample of claims paid by the State Medicaid agency for Title XIX recipients reviewed by a PSRO
- Retrospective review of the total universe of claims paid by the State Medicaid agency for Title XIX recipients reviewed by a PSRO

Either of these models could be implemented by the State Medicaid agency itself, or on behalf of the State by the State's fiscal agent (if applicable). The first model to be presented will be that which involves retrospective review of a sample of claims. For ease of presentation, the random sample selection approach which could be implemented by the State agency will be discussed initially, followed by a discussion similar approach which could be implemented by the State's fiscal agent. These two approaches should be considered as variations of a single model, namely, retrospective review of a sample of paid claims.

3.3.2 State Agency Review of a Sample of Paid Claims

Most States have implemented systems for retrospective reviewing claims submitted for inpatient service rendered to Title XIX recipients. For States who choose to monitor PSRO performance to determine the impact of PSRO review on their program, these existing systems can be utilized as the base for the PSRO monitoring system. The system which will be discussed below includes a procedural outline as well as potential data display formats to assist States analyze results of the claims review.

The rationale for retrospectively drawing a sample of paid claims is that it is an efficient, cost-effective method for reviewing services which have been utilized, providers who have delivered the services, and dollars which have been expended for the services. If the sample of claims is selected properly and in sufficient quantity, the results of the review should give State agency staff an accurate overview of utilization and expenditures for the period reviewed. If review of a sample of claims is conducted regularly, State agency staff will be able to perform trend analyses to determine if currently emerging patterns of utilization and expenditures are similar to those of the past. If these analyses indicate that PSRO review is either increasing or decreasing utilization of services and/or expenditures, determination must be made to ensure that comparability exists between the periods reviewed for the eligible population, covered benefits, and provider reimbursement schedules. Further discussion on analysis of sample claims review outcomes and limitations of the data will follow presentation of the procedural process for performing review of a sample of claims. The procedural process for implementing such a system will be described below.

1. Select a random sample of paid inpatient service claims. In the following example 7 percent has been arbitrarily selected for determining sample size. States which utilize this type of review system typically select a sample size which ranges

between 5-7 percent of submitted claims. Sample selection techniques will be discussed in section 3. 3. 3.

2. Screen the selected sample of claims for lengths of stay which exceed State specified norms. Claims which pass this screen, usually performed by clerical staff, are not reviewed further. Claims which fail are referred to medical specialists (such as nurses) or to physician staff for verification.

3. Claims which fail the second review are flagged to indicate a review of the service recipient's hospital chart is indicated. The PSRO is notified at this point that a review of the record will take place, and is requested to make required arrangements.

4. Obtain access to copies of the hospital charts and supporting data for the flagged claims to the extent permissible. These charts will be required for the review process. The PSRO can obtain copies of the chart from the hospitals, the hospital can abstract the necessary information from the charts and forward it to the State agency, or the hospital can mail a copy of the charts to the State agency if confidentiality is ensured. State agency staff can also go to the hospitals and review the charts on-site.

5. The charts are reviewed by physicians designated by the State agency to determine if the days of stay or admission were justified by the patient's condition. If further information is required, the PSRO should be contacted. If there is no further question concerning the chart, it is either returned to the hospital or the review is otherwise completed. If the length of stay or admission is judged to be inappropriate, the PSRO is notified of this determination and is requested to respond within a specified period of time. If an explanation is not forthcoming, the

claim is considered to be unjustified. If the PSRO disputes the State's determination, but is unable to convince the State's reviewer that the admission and/or length of stay were appropriate, the claim is considered to be unjustified for purposes of State agency records. It should be emphasized that PSRO review determinations concerning medical necessity are final and that claims submitted for these services (if included in the State plan) must be paid by the State regardless of whether they would have been passed by the State's own utilization review system or are considered as unjustified by the State.

6. The State agency will maintain records on this review process. The type of information which would be tallied on a monthly, quarterly or semiannual basis would include:

   - Number of claims reviewed for excessive LOS (by hospital and PSRO area)
   - Number of claims for which length of stay exceed specified norms for the diagnostic category
   - Number of claims for which a hospital chart review was deemed to be required
   - Tally of outcome of the hospital chart reviews and PSRO responses
   - Ratio of unjustified claims to total claims submitted (by hospital and PSRO area)

7. Periodically contact each PSRO whose ratio of unjustified claims exceeds a previously agreed upon limit. HSQB and the appropriate Regional Office should also be contacted. A meeting should be arranged between the State agency, PSRO and other interested persons to work out a mutually acceptable plan of corrective action.

Exhibits 4 and 5 present potential formats for displaying the data discussed under item 6. Exhibit 4 deals specifically with claims reviewed internally by the State Medicaid agency staff. Each PSRO and the hospitals for which it is responsible is separately listed. The total claims reviewed includes those included in the 7 percent sample review for excessive length of stay. In this example the 7 percent sample is interpreted to mean 7 percent of total claims received from each PSRO during the month of December. It should be emphasized that as State agencies begin to discover, as a result of their review of the data, that problems might exist, State agency staff should immediately contact the PSRO in question. The State agency should be closely involved in all discussions which deal with these problems as soon as it has been established that a potential problem exists. If the State and PSRO work together in a cooperative spirit, the entire review and monitoring process will be more likely to proceed smoothly.

These claims are reviewed by State agency staff for excessive lengths of stay by comparing the indicated diagnosis against State accepted norms. Those claims indicating an excessive length of stay will be reviewed by professional persons either employed by or under contract to the State agency. If questions still remain, the chart itself is reviewed.

Exhibit 5 is a representation of the hypothetical outcome of the review of charts questioned by State Medicaid agency representatives. This report would be produced after the charts have been reviewed and after the PSRO has responded to the State agency's inquiries about these cases. This exhibit includes the following data:

- Total number of records reviewed
- Number of records for which the preoperative stay was determined to be excessive
- Number of records for which the postoperative stay was determined to be excessive

Statewide Summary of Retrospective Review of A Sample of Claims

Prepared by State Medicaid Agency

Month Ending: December 31, 1976
PSROs Reporting Title XIX Discharges

ADF Medical Care Foundation
ABC PSRO
DBR Health Care Review Organization
XYZ Foundation for Medical Care

	7% Sample of PSRO Invoices Reviewed for Excess LOS	Invoices Indicating Excessive LOS	Other	Records Reviewed
ADF Medical Care Foundation				
ABC Hospital	13	1		
DEF Hospital	14	3		2
GHI Hospital	97	20		16
JKL Hospital	9			
MNO Hospital	16	2		2
PQR Hospital	36	1		1
STU Hospital	78	8		6
Subtotal	263	35		27
ABC PSRO				
TLC Hospital	3			
ACF Hospital	5	1		
DTP Hospital	8	2		2
TUR Hospital	3	1		1
Subtotal	20	4		3
DBR Health Care Review Orgn				
YOS Hospital	16	2		1
WTB Hospital	6	1		
LNM Hospital	7	2		2
RUL Hospital	5			
TTB Hospital	6	1		1
XNI Hospital	4			
Subtotal	44	6		4
XYZ Fdn for Medical Care				
ALA Hospital	2			
KBB Hospital	12	3		2
MGB Hospital	9	2		1
SMJ Hospital	3			
Subtotal	26	5		3
TOTALS	353	50		37

Exhibit 4

Summary of Medical Record Review Outcome

Prepared by State Medicaid Agency

Month Ending: December 31, 1976
PSROs Reporting Title XIX Discharges

ADF Medical Care Foundation
ABC PSRO
DBR Health Care Review Organization
XYZ Foundation for Medical Care

	Records Reviewed	Pre-Op Days Excessive	Post-Op Excessive	Weekend Admission Excessive LOS	Excessive LOS Justified	Other	Ratio Unjustified Claims to Total Claims
ADF Medical Care Foundation							
ABC Hospital							
DEF Hospital	2	1		1			
GHI Hospital	16	5	4	3	4		
JKL Hospital							
MNO Hospital	2		1		1		
PQR Hospital	1	1			1		
STU Hospital	6	2	2	1	1		
Subtotal	27	9	7	5	6		21:3757 [0.558%]
ABC PSRO							
TLC Hospital							
AFC Hospital							
DTP Hospital	2	1			1		
TUR Hospital	1		1				
Subtotal	3	1	1		1		2:286 [0.69%]
DBR Health Care Review Orgn							
YOS Hospital	1	1					
WTB Hospital							
LNM Hospital	2		1	1			
RUL Hospital							
TTB Hospital	1				1		
XNI Hospital							
Subtotal	4	1	1	1	1		3:629 [0.476%]
XYZ Fdn for Medical Care							
ALA Hospital							
KBB Hospital	2	1			1		
MGB Hospital	1		1				
SMJ Hospital							
Subtotal	3	1	1		1		2:371 [0.539%]
TOTALS	37	12	10	6	9		28:5043 [0.555%]

Exhibit 5

- Number of records for which a weekend admission was responsible for an excessive length of stay
- Number of records for which the length of stay originally appeared to be excessive but was, in fact, justified by the patient's condition
- Number of records considered justified for other reasons
- Number of records for which an unspecified reason explains the LOS
- Ratio of unjustified claims (total of preceding columns, excluding the LOS justified column) to total claims submitted to the State agency by the PSRO. The percentage which this ratio represents is also presented.

It is recognized that this monitoring system has limitations in that only a sample of claims are reviewed instead of the entire universe of claims. There are possible variations of this system which could be initiated without too much difficulty. Two of these variations include the following:

- Select a random sample of claims from a previously screened group. Prior screening could be used to eliminate diagnostic categories for which length of stay problems rarely occur (i.e., normal child birth.)
- Choose a specified number of diagnostic categories and select a sample of claims only from these categories. The categories could be fixed for a certain period of time and then revised to include new diagnoses.

In addition to review of a sample of claims for monitoring purposes, State agencies could perform statistical analyses on the data to develop a more complete picture of PSRO impact on the cost of providing care and utilization of services. Statistical studies might include the following:

- Comparison of overall length of stay pre- and post-PSRO review implementation
- Determination of the most frequently occurring diagnoses causing admissions to hospitals pre- and post- PSRO implementation
- Analysis of hospital stays which are less than three days to determine if the number is increasing or decreasing since PSRO review has been initiated
- Analysis of the cost of inpatient services provided to Title XIX recipients pre- and post-PSRO review implementation

The most troublesome limitations which State agencies will encounter in trying to perform these analyses will be unavailable or unsuitable pre-PSRO baseline data. Unless data have been collected in the same form for several years prior to PSRO implementation as well as following implementation of PSRO review, it will be difficult for State agency staff to determine if the data elements used in the studies are comparable. For example, if frequency distributions are to be developed for the top twenty principal diagnoses for two years pre- and post-PSRO review implementation, it would have to be determined that the definition of what constitutes a principal diagnosis has not been altered throughout the specified four-year period.

If cost analyses are to be performed to determine if, as a result of PSRO review, State agencies are expending more funds to provide inpatient services to Title XIX recipients, a statistical study would have to build controls to compensate for the following:

- Inflation factors
- Changes in benefits included in the State plan
- Changes in benefit restrictions
- Increases or decreases in eligible population mix and size
- Other relevant demographic factors

If adequate controls are not appropriately applied to statistical analyses, the results of the studies will not be valid or useful to those attempting to derive information from them. Another consideration is that these types of studies can be time consuming and, therefore, costly to perform on a regular basis. States must weigh anticipated costs of studies against benefits expected to be derived to determine what types of studies are reasonable and worthwhile to perform as part of their PSRO monitoring effort.

3.3.3 Relevant Issues and Implementing Guidelines

In implementing this approach to monitoring PSRO performance certain issues must be taken into consideration by the State to determine what impact they have on their monitoring plans. State findings should be routinely discussed with PSROs. The discussion presented below will be keyed to the relevant steps of the previously outlined approach.

A. Random selection — If a random sample of claims is chosen as a method for monitoring PSRO performance, it is important that the sample be large enough to accurately reflect what is going on in the PSRO area. The purpose of the review is to project the findings from review of a limited sample of claims to all claims which have been reviewed by the PSRO in a given period of time. If the sample size is too small, it will be impossible to make valid projections. Estimations of sample size can be done scientifically through application of statistical techniques, such as the binomial distribution, which would result in different size samples being selected for each review cycle. Another alternative technique is to establish a fixed percentage of claims to be sampled which is uniformly applied during each review cycle. This latter approach may be adequate to meet the needs of most States, especially if, over time, it is demonstrated that the sample drawn does present an accurate picture of the results of PSRO review. The sample size suggested in the example in Exhibit 4 is a fixed 7 percent random sample of claims received from each PSRO. Such a sampling

approach ensures that each PSRO is appropriately represented in the analysis. There are a variety of techniques which can be used to select the sample. Random selection in which the Medicaid number is utilized is one approach. It involves matching the terminal digit of the Medicaid number on the claim with a number selected in a random manner to identify that claim for review. A second method involves selecting a number from 1 to 9 at random and then pulling every tenth or twentieth claim (depending on the interval desired.) In the example, a suggested method of selection was not delineated because each State will have to make its own determination concerning its needs. It should be noted, however, that in the example the distribution of claims reviewed among hospitals within the PSRO is not controlled to reflect 7 percent of claims, because it was believed that such a guideline would be administratively difficult for State agency staff to follow. The State agency should periodically review the sample size selected for each hospital to determine if there is proportional representation between the number of claims received from each hospital and the number of claims reviewed. If a distribution problem exists, methods for selecting the sample will have to be adjusted, or a special review of the underrepresented hospitals claims be performed. It would be possible for the State agency to select a percentage sample of claims received from all PSROs within the State. This approach would create additional problems of ensuring proportionate representation of each PSRO, as well as among hospitals within each PSRO.

B. Review claims for lengths of stay which exceed State specified norms — This procedure assumes that claims which are forwarded to the State agency are coded for diagnoses. If codes are not required by the State, it will be extremely difficult to determine comparability between a handwritten diagnosis and printed HICDA-2 or ICDA-8 diagnostic codes. It should be noted that since PSROs certify individual lengths of stay on the basis of medical necessity, length of stay norms utilized by the State and PSROs may not always be in agreement.

C. Refer claims with lengths of stay which exceed State specified norms to physician staff or other medical specialists qualified to review the PSRO's determination on medical necessity.

D. Review hospital charts — Several approaches can be taken in accomplishing the task. The PSRO should be notified by the State of the records selected for review in all cases. The PSRO could get the records from their hospitals for the State agency to review. Another alternative would be for the hospital to be notified of the impending review and requested to send a copy of the designated medical record to the State agency for review. Finally, a physician or medical specialist employed by the State agency in a consultant capacity could go to the hospital and personally review the record. This latter approach involves logistical problems of travel and ensuring the availability of adequate staff.

E. Determine if the services rendered were medically necessary based on professional judgment and factual information gathered from other relevant sources. In determining whether the length of stay indicated on an individual claim is excessive, or the admission was justified, the following items are some of the variables which could be considered.

- The diagnosis code on the claim is compared to the diagnosis indicated in the chart to verify that they coincide
- Overall quality and completeness of the medical record is noted.

The State agency could review the chart in light of the variables presented above. The decision as to whether a particular length of stay is medically necessary or not will be made through use of implicit and/or explicit criteria, depending on the individual agency's predetermined ways of conducting reviews. It is expected that these professionals would be instructed to follow the State's guidelines and that the PSROs would be informed of these guidelines.

The variables suggested above provide some guidance to the State in making determinations of whether admissions or lengths of stay were justified. While admittedly professional judgment is a major factor in making determination, it is emphasized that the State's reviewer should be impartial. If the PSRO agrees with the State's determinations there will be no problems. If the PSRO does not agree, the State and PSRO will have to mutually work out their differences. A particularly difficult situation will be when the issue at hand is a matter of quality of care versus dollars expended.

3.3.4 Retrospective Review Staff Requirements

The type of staff required to perform retrospective review include the following:

- Clerical staff to select the random sample and perform the first level review concerning excessive length of stay (applicable to manual system).
- Medically trained analytic staff to perform second level review to verify that the length of stay indicated on the claim exceeds Medicaid norms for the diagnostic category. These staff persons should also be capable of performing simple statistical studies such as, length of stay trend analysis, cost comparison and other studies considered to be important by the State agency.
- Physicians or other highly trained medical staff to review the charts of those patients whose length of stay was declared excessive at the second level review. These persons will discuss these cases with the PSRO, where appropriate.
- Medically trained administrative staff who are able to communicate findings and apparent problems to the PSROs. It is particularly important that these staff persons be capable of

communicating with the PSRO's administrative staff, the review coordinator supervisor, and the review coordinators who are working in the field.

3.3.5 Protocol For Fiscal Agent Review

For States which utilize the services of fiscal agents for review and payment of claims submitted by providers of services to Title XIX recipients, a possible random sample monitoring approach could be similar to the one being initiated by the Bureau of Health Insurance (BHI) with Medicare fiscal intermediaries. BHI's system is based on postpayment review of a 20 percent sample of PSRO cases by the fiscal intermediary. For purposes of illustration, the same percentage sample is applied herein. The reviews of selected cases are conducted monthly, with summaries being compiled quarterly for submission to the State agency. This is an exception based system in that only questioned cases are intended to be reviewed in depth by the State agency and its PSROs.

Fiscal agents will be responsible for initiating and monitoring this exception based system. The system required a cooperative relationship among the State agency, fiscal agents, and PSROs in order to be a useful monitoring tool. The basic components of this system are as follows:

1. The fiscal agent selects on a monthly basis a 20 percent sample of paid inpatient service claims. The sample selection process will depend upon procedures agreed upon by the State agency and its fiscal agent. The sample should include a proportional number of claims from each hospital relative to the total number of claims submitted.
2. Claims will be reviewed by fiscal agent physicians as to whether more or less days would have been paid by the fiscal agent than were certified as being medically necessary by the PSRO.

3. For claims where more or less days would have been paid by the fiscal agent, these claims are considered to be questioned cases.

4. A summary report is prepared on the outcome of the review of the 20 percent sample. This report is submitted to the State agency.

5. A copy of this summary report is submitted to the PSRO and discussed with the PSRO.

6. A summary of questioned case report will be prepared for each one. These reports may include:

   - PSRO name
   - Hospital name and/or number
   - Patient's name*
   - Patient's Medicaid number*
   - Dates of admission and discharge (or death)
   - Indication as to whether the fiscal agent would have paid more or less
   - Number of days involved
   - Fiscal agent physician's rationale for questioning the case
   - Fiscal agent physician's signature
   - Date of signature

7. Summary of questioned cases reports will be prepared by the fiscal agent on a quarterly basis and submitted to the State agency.

8. Copies of the summary of questioned cases reports will be submitted to the PSRO.

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*Confidential information not to be forwarded elsewhere.

9. Opportunities to discuss the cases are arranged by the State agency between the fiscal agent and PSRO, upon request. the State's discretion, the fiscal agent and PSRO can meet to discuss the cases without involving State agency staff.

Exhibit 6 presents a sample format as a summary of postpayment review of PSRO cases. In this example each of the PSRO's hospitals is named and its delegated status indicated. The total number of claims received by the fiscal agent from each hospital for the quarter is presented. A proportionate number of claims from each hospital is included in the sample (in this case 20 percent). The number of cases is presented in which the fiscal agent would have paid for more or less days than certified medically necessary by the PSRO. In this example, ancillary service review has not yet been implemented by the PSRO.

Exhibit 7 is a suggested format for presenting the summary of each questioned case. It is up to the discretion of the fiscal agent and State agency to develop the format for reporting this information.

3.3.6 Protocol For Automated Claims Review Systems

For States or for fiscal agents acting on behalf of States, with automated claims processing/review systems, a possible monitoring approach could take the general form similar to the system developed by California. Such a system would have two major components:

A. All claims from PSROs would be passed through the normal automated edit checks during the payment process. Those that fail the admission/length of stay norms in these screens would still be paid, but would be reviewed initially by clerical staff who would determine if clerical errors caused the claims to fail the screen. If it were unable to be determined from this review whether the claims should have failed the screen, they will be referred to trained review specialists who are, in general, persons knowledgeable in the health care field, (such as nurses) and then, finally, to physician consultants. The State

Summary of Postpayment Review of PSRO Cases

Prepared by Fiscal Agent

Quarter Ending: December 31, 1976
Fiscal Agent Name: XYZ Ins. Co. ID #12345
PSRO Name: ADF Medical Care Foundation

Hospital Provider Name	Delegation Status FD/ND/PD	Total # Claims Rec'd.	Sample Size Sel. for Review	Questioned Cases Routine Admissions				Ancillary Service (If Applicable)	
				More		Less		More	Less
				# Cases	# Days	# Cases	# Days		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
ABC Hosp.	ND	2320	463	2	5	3	7	NA	NA
DEF Hosp.	PD	4760	952	3	8	5	12	NA	NA
GHI Hosp.	FD	9850	1970	10	22	6	11	NA	NA
JKL Hosp.	FD	2103	420	1	3	0	0	NA	NA
MNO Hosp.	FD	5670	1134	4	6	2	5	NA	NA
PQR Hosp.	ND	900	180	0	0	1	2	NA	NA
STU Hosp.	PD	1340	268	2	5	1	3	NA	NA
TOTALS		26,943	5389	22	49	18	40	NA	

Prepared by: Ms. Smith

Date: January 24, 1977

Exhibit 6

SUMMARY OF QUESTIONED CASE REPORT

1. PSRO _____ 2. Provider _____

3. Patient's last name* _____

4. Medicaid number* _____

5. Admitted _____ Discharged/Died _____

6. Would the fiscal agent have approved: More _____

Less _____

7. Number of days involved _____

8. Rationale for disagreement:

_____

_____

_____

_____

_____

_____

_____

_____

_____

9. M. D. Signature _____

10. Date _____

*Confidential information not to be forwarded elsewhere.

Exhibit 7

agency would make the determination as to whether the stays were in fact justified and the PSRO would provide input as described in Section 3.3.2. The States would keep records of the numbers of "unjustified" claims. The ratio of unjustified claims to total claims reviewed would be periodically calculated by the State to determine if this number falls within predetermined guidelines. Each State which utilizes this system must set its own "level of acceptability" with regard to unjustified claims. It is also presumed that the States will receive input from their PSROs concerning these criteria. States and PSROs must work out the details of corrective actions which should be taken if the unjustified claims ratio falls outside of established limits. Reports on this aspect of the system would reflect the outcome of retrospective review of individual claims.

B. The claims processing system would keep track of average length of stay, and total days of stay per thousand eligibles in the PSRO area. These indicators would periodically be compared against either pre-PSRO baseline data or against other specified norms. Action would be indicated if the PSRO's days of stay or average LOS exceeded the comparison standard by a stipulated percentage for a given time period, say six months. If it were shown for individual claims that the PSRO's days of stay or average LOS had been reduced relative to the comparison standard for a particular diagnostic category, a notation of positive performance would be made. This approach would give the PSRO "credit" for cases in which their criteria were more rigid than the State's screens. The computer programs could be written so that these cases would offset cases in which PSRO authorization exceeded the screens. Reports on this aspect of the system would focus on statistical analysis of the composite review data.

Such a monitoring concept has several advantages which include the following:

- It reviews all claims.
- It can be done with little or no increase in cost to the State, since the incremental cost of screening claims is essentially zero.

- It only looks at outcome. The PSRO is free to follow its own review procedures as long as its experience is satisfactory. Only those claims which are causing problems need further attention.
- It is completely objective in terms of both procedures and performance standards. Objectivity is vital in this case, because both the State and the PSRO have previously agreed upon benchmarks against which performance is being compared.

It can be expected that each State will want to tailor this concept to its own particular needs and system (e.g., setting its own norms, action levels, review criteria, etc.) but in general, the basic approach should be applicable to all States which currently have initiated the Medicaid Management Information System (MMIS) or other automated claims review and processing systems.

The critical components of the automated monitoring system are the retrospective and statistical performance evaluations. While States may differ somewhat on the details of automated review, a general description of how the process might work is as follows:

1. Review all claims for accuracy, completeness, etc.
2. Keypunch claims and submit to computer.
3. Pass all claims through the basic MMIS-type LOS/admission screens, print out the claim number, other review data, and approve the claim for payment. Clerical staff may be used first level review following computer screen.
4. On a monthly or more frequent basis, refer all failed claims which have not been otherwise disposed to trained medical specialists (such as nurses) and then to physician staff for medical review. These staff can be full-time employees, field consultants or other available State personnel.

5. Obtain copies of the hospital chart and supporting data for rejected claim if the problem cannot be resolved through discussions with the PSRO. These charts will be required for the review process. The PSRO can obtain a copy of the charts, the hospital can make a copy of the charts, or the charts can be reviewed on-site by the assigned review physician.

6. Claims that are judged to contain excessive days of stay or inappropriate admissions are referred to the PSRO for explanation. If an explanation does not arrive within a certain time period, it should be deemed to be an unjustified claim for purposes of State agency records. If the PSRO cannot resolve the disagreement concerning the appropriateness of the admission or length of stay, the claim should also be considered unjustified by the State. However, PSRO determinations on admissions or lengths of stay are final and claims for services included in the State plan which are considered unjustified for purposes of State agency records must be paid.

7. Periodically, the State should compute the unjustified claim ratio, e.g., the number of days of stay authorized by the PSRO divided by the total state-allowed days of stay over the given time period. If this ratio exceeds some predefined boundary (say 5%) for a given time period (say 3 months), and if the statistical criteria are not met (see below), then meetings should be held with the PSRO to work out a plan of corrective action.

In addition to this retrospective process, a statistical test of PSRO performance should be developed as follows:

1. A baseline period for total days of stay comparison could be specified in the State plan for monitoring PSROs. The baseline

could include the previous year's total days of stay prior to PSRO review, implementation, a moving average, a nearby non-PSRO comparison area, or other agreed upon bases. The basis for computing total eligibles should also be specified so that changes in the number of eligibles is included in the formula.

2. On a monthly basis, the information system should compute average LOS and total days of stay per thousand eligibles in the PSRO area, either in total or by major diagnostic class. This result should be divided by the current comparison baseline value. If the result exceeds some previously-specific limit (say 5%) for a set number of months, (say 3), meetings should be held with the PSRO to work out corrective actions.

While each State will have to work out the details of its own monitoring system, Exhibits 8, 9, and 10 illustrate the process of retrospective and statistical review and may provide some help in structuring specific systems.

Exhibit 8 illustrates a quarterly worksheet for statistical review of a given PSRO. This worksheet could be filled out by the claims processor, whether it be the State or fiscal agent. It simply compares average LOS and total days of stay per thousand against the previously-established baseline. The diagnosis-specific details provide an indication of where problems exist; the totals provide the basic performance indicator.

Exhibit 9 illustrates a quarterly worksheet for retrospective review. This report must be prepared by the State, since State consultants will be doing the review of remanded claims. Again, the tabulation process is straightforward. Column (a) shows the number of each claim that failed the automated screen criteria, and column (b) shows how many days were certified by the PSRO for that claim, Column (c) shows how many days would have been authorized in accordance with State screens, and column (d) shows days that would actually have been

STATISTICAL CLAIMS REVIEW REPORT

Prepared by: State or Fiscal Agent | Date: 4-15-77

Period From: 1-1-77 Through: 3-31-77 | PSRO: XYZ

Indicator Diagnosis	Current Avg. LOS	Performance Days/1000	Baseline Avg. LOS	Comparison Days/1000	% Difference Avg. LOS	% Difference Days/1000
Diabetes	5.4	12	4.2	11	+1.2	+1
MI	11.2	6	10.1	6	+1.1	0
Appendicitis	4.1	8	4.5	7	-0.4	+1
BPH	6.0	3	7.2	3	-1.2	0
T & A	2.5	12	2.4	13	+0.1	-1
TOTAL	5.84	41	5.68	40	-0.16	-1

Exhibit 8

RETROSPECTIVE REVIEW REPORT

Prepared by: State		Date: 4-15-77	
Period From: 1-1-77	Through: 3-31-77	PSRO: QRW	
Total Certified Days This Quarter: 890		12 Months to date: 3420	
Total Days This Quarter: 889		12 Months to date: 3424	

REVIEWED CLAIMS

Claim No. (a)	Certified Days (b)	State Approved Screens (c)	Days After Review (d)	Difference (e)
29310	5	4	5	0
30312	10	9	9	1
42130	8	4	6	2
42139	15	11	14	1
42190	12	10	10	2
TOTALS	50	38	44	6

Performance: $\frac{\text{Total Certified Days}}{\text{Total Authorized Days*}} = \frac{3420}{3424-6} = 1.00$

*Equals total days - total difference (column e)

Exhibit 9

PERFORMANCE SUMMARY

Prepared by	State	Date	4-15-77
Period From	1-1-76	Through	3-31-76

PSRO Name	Statistical — Current/Baseline				Retrospective — Certified/Authorized	
	Quarter		12 Months to date		Quarter	12 Months to date
	LOS*	DOS*	DOS	LOS		
QRW	1.01	.99	1.05	1.03	1.00	1.03
XYZ	1.03	1.03	1.10	1.13	1.02	1.09

*LOS - Length of Stay

DOS - Days of Stay

Exhibit 10

paid by the State after review. Column (e) then shows the difference (certified vs. would have been authorized). The basic performance measure is then total certified days divided by the total number of days that would have been authorized if the State had done the review.

Finally, Exhibit 10 shows summary performance statistics for each PSRO for both the statistical and retrospective components of monitoring. Both quarterly and yearly data are presented in case the action criteria are a combination of current and long-term performance. This worksheet provides the basic information for the States to use in determining what impact each PSRO has had with regard to service utilization.

3.3.7 Relevant Issues and Guidelines

In implementing this automated review concept, a number of issues will need to be considered and resolved by the State. These include:

1. Staffing. The system will require the use of clerical staff, trained medical specialists and physicians to review failed claims and to work with the PSROs. Most States who run automated claims systems already have access to such personnel, either working directly for the State (as employees or consultants) or through the fiscal agents. It is not likely that this staff will need to be expanded for the monitoring function; indeed, States with prior authorization systems may find that they can reduce their consultant staff in PSRO areas.

   The monitoring system will also require trained analytical staff to collect and analyze performance data. Such staff should usually be available as part of the data processing department (State or fiscal agent), and little or no additional staff should be required.

2. Data Processing. The claims system will require some modification to pay all PSRO claims (whether screened out or not), produce a special printout of remanded PSRO claims, and compute the ratios of unjustified claims and total days of stay. The reprogramming required for these functions should be minimal.

3. Acceptability of Screens and Review Criteria. To the extent possible, the automated screens should be discussed with the PSROs and accepted by them as reasonable. The procedures used for reviewing remanded claims should be as objective as possible, and should also be discussed with the PSROs prior to implementation. These actions should minimize the possibilities of problems between the State and PSROs on unresolved claims.

4.0 CONCLUSION

This manual has presented two basic models with possible adaptations as generic approaches to States for use in their efforts to monitor the activities of PSROs. These protocols have been briefly presented to outline procedures and possible reports which could be utilized in their implementation. While presenting them separately, Medicaid Bureau and HSQB have noted that individual components of each could be integrated into a different kind of system, particularly tailored to meet the needs of a specific State. The Medicaid Bureau and HSQB have worked together to develop these alternative approaches to be presented to the States as possible mechanisms for monitoring their PSROs. While it was not possible to integrate the individual characteristics of each State's current claims review mechanisms into these approaches, the Medicaid Bureau and HSQB anticipate that States will be able to adapt these protocols to their own needs.

APPENDIX A

SRS AT 76-140

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

PROGRAM INSTRUCTION

ACTION TRANSMITTAL
SRS-AT-76-140
September 3, 1976

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT: Title XIX, Social Security Act - Involvement of State Medicaid Agencies in PSRO Implementation

ATTACHMENT: Explanation of (a) the stages of State involvement in PSRO implementation, (b) Federal and State monitoring of PSRO performance, and (c) procedures for States to make complaints about PSRO performance.

RELATED ISSUANCE: This AT supersedes SRS-IM-76-27 (MSA), issued June 22, 1976.

ACTION REQUIRED: Submit State plans for monitoring PSRO performance to the SRS Regional Commissioner prior to their implementation.

INQUIRIES TO: SRS Regional Commissioners

Commissioner
Medical Services Administration

INVOLVEMENT OF STATE MEDICAID AGENCIES IN THE PSRO PROGRAM

To assist the Department in the effective implementation and administration of the PSRO program and to assure the States an active role in those aspects of the program directly impacting on the States, a comprehensive approach to State involvement in the program has been developed. The approach provides for: (1) stages of State involvement in PSRO implementation, (2) Federal and State monitoring roles, and (3) a complaint system through which State concerns regarding the impact of PSRO review determinations on State expenditures or the quality of care given to Medicaid patients may be addressed

INVOLVEMENT OF STATE MEDICAID AGENCIES IN THE PSRO PROGRAM

INTRODUCTION

To assist the Department in the effective implementation and administration of the PSRO program and to assure the States an active role in those aspects of the program directly impacting on the States, a comprehensive approach to State involvement in the program has been developed. The approach provides for: (1) stages of State involvement in PSRO implementation, (2) Federal and State monitoring roles, and (3) a complaint system through which State concerns regarding the impact of PSRO review determinations on State expenditures or the quality of care given to Medicaid patients may be addressed.

With enactment of Public Law 92-603 and the establishment of the PSRO concept, the Congress, the Administration, and the Department made a commitment to the PSRO approach as the way to assure the quality and necessity of institutional health care reimbursed through federal funding. It was anticipated, however, that a long lead time would be required before PSRO could be fully implemented and recognition was given to the necessity of leaving existing Medicare and Medicaid Utilization Control mechanisms in place until an orderly phase-in of PSRO could be accomplished. Furthermore, logic dictates that even after PSRO assumes "binding review", States responsible for administering Medicaid programs would want to be assured that PSROs are effective in carrying out their assigned responsibilities. This can be accomplished by a State-designed system for monitoring PSROs.

The Department and more specifically, the Medical Services Administration, strongly supports State monitoring of PSROs. Although monitoring is not required, we believe that only through a systematized approach to monitoring can a State be assured that PSRO review is effective and that State and Federal dollars for institutional health care are being appropriately spent for necessary and quality care. States should be aware, however, that Federal financial participation for State monitoring of PSRO performance is contingent upon monitoring functions not duplicating the purpose of the PSRO review. More information regarding ways States may be affected by FFP determinations is provided in later sections of this transmittal.

The Department has the responsiblity to continuously monitor the progress and performance of the PSROs and, as indicated earlier, States are not required by the Department to do monitoring. However, as a supplement to Federal monitoring, State monitoring to assure the integrity and effectiveness of PSRO performance can be extremely helpful. As a result of monitoring PSRO performance, the States may identify areas of concern to both themselves and the Department. In subsequent sections of this document procedures are described for States to report problems associated with PSRO review to the Department and for departmental response to State concerns.

STAGES OF STATE INVOLVEMENT IN PSRO IMPLEMENTATION

To assist PSROs in carrying out Medicaid review and assure States a role in implementation of the PSRO program, Department policy provides the following stages for State involvement.

(1) Conditional Designation

PSROs in the planning phase must contact Medicaid State agencies to establish an early State-PSRO relationship during the development of the organization's formal plan for assumption of PSRO functions. Applications for conditional designation containing formal plans and implementation schedules are to be reviewed by State Medicaid agencies. State comments are considered in the Departmental review, and if a State has serious reservations about the organization's review plan or any other matter pertaining to the application, the Department will seek resolution of State concerns prior to making the initial decision on the organization's competency to exercise review and the decision to designate the organization as a conditional PSRO.

(2) Procedures for Correlation of Functions

Each conditional PSRO shall develop administrative procedures for correlating its activities with those of the State prior to beginning review. Departmental policies strongly encourage PSROs to incorporate these administrative procedures in a memorandum of understanding (MOU) to be submitted to the Department for approval prior to the initiation of review. Where a State monitoring plan has been fashioned it may be made a part of the MOU, but in any case, PSROs must consult with the State and work out appropriate procedures, including those pertinent to State monitoring. Assistance in working out these procedures is available from the Department in the event that the PSRO and State are unable to reach agreement.

At the option of the State, administrative procedures may provide that PSRO review be advisory (as opposed to binding) for 60 days after the PSRO begins review in the first hospital so as to allow for administrative adjustments during the initial transition to PSRO review.

(3) Monitoring During the Conditional Period

States are strongly encouraged to monitor PSRO performance by utilizing information provided through existing data collection mechanisms. Upon request by the State, information will be available from routine PSRO reports, regular contacts (including on-site

visits) between the PSRO and HEW project officers, and ongoing appraisal and evaluation activities. States may supplement these mechanisms with additional State data and may conduct case by case monitoring. The Department will implement a system, described below, to assure a prompt Departmental response to State concerns identified at any time during the conditional period.

(4) Conversion from Conditional to Operational Status

At the end of the 24 month conditional period, State recommendations will be considered prior to the decision to convert the PSRO from conditional to operational status. If PSRO performance warrants, the Department has the option to redesignate the PSRO for another conditional period.

(5) Ongoing Monitoring

States are encouraged to continue monitoring even after a PSRO is converted from conditional to operational status. However, monitoring is expected to be less intensive after the conditional period. An intensive evaluation by the Department of a PSRO's capabilities will precede conversion from conditional to operational status. The Department will continue to monitor operational PSROs. States will be encouraged, as in the conditional phase, to participate in site visits conducted by the Department and to utilize the results of departmental monitoring activity in conjunction with their own monitoring.

FEDERAL AND STATE MONITORING ROLES

Routine quarterly and annual reporting by PSROs, special studies, frequent contacts with Departmental staff, including site visits, and the results of appraisal and evaluation activities are all activities associated with Departmental monitoring and assessment of PSRO performance. States will be provided information resulting from Departmental monitoring but, in addition, States may elect to institute their own monitoring activities.

Federal Matching

The Federal government will match State expenditures for a variety of monitoring activities. In essence, the Department will provide FFP in the cost of State monitoring intended to assess the propriety and effectiveness of PSRO review of care provided Medicaid patients. However, as indicated earlier, the Department will deny FFP for similar or identical State functions when those activities duplicate the purposes of PSRO

review or serve to override PSRO decisions as to medical necessity. In addition, if it can be established that a State is not complying with P.L. 92-603, Section 1164, whereby PSRO review is incorporated in the operation of the Medicaid program and PSRO decisions are binding, the Department would then take appropriate action to hold the State out of compliance.

Legitimate State monitoring may be directed, on a sample basis, at assessing individual patient care and/or may be focused retrospectively on profiles of patient care. Since the various activities may include case-by-case patient assessment, evaluation of the PSRO review process, or making statistical comparisons of data, numerous State monitoring functions may, in fact, be similar or even identical to activities routinely performed by PSROs. The question of Federal matching requires a determination that such State activities were valid approaches to monitoring and that the resulting information was used to assess PSRO performance. On the other hand, FFP would be denied if it could be established that information gained from State monitoring was used primarily for the purpose of overriding PSRO decisions or that monitoring procedures reflected PSRO activities so minutely and for such extended periods of time as to belie the assertion that their purpose was exclusively that of assessing a PSRO's performance. In particular, if a State monitoring plan includes a proposal for case by case monitoring, the Department will scrutunize the proposed monitoring activities very carefully to ensure that such monitoring does not duplicate the purpose of PSRO review.

Submittal of Monitoring Plans

To secure appropriate PSRO collaboration and to assure DHEW use of the results of State monitoring, State agencies, prior to implementing their monitoring activities, will submit to SRS for approval a detailed description of their monitoring plans. The plans should be accompanied by comments from (1) those PSRO(s) whose performance will be monitored, and (2) the hospitals impacted by this effort. (Comments from hospital associations representing member hospitals will be acceptable.) If comments from PSRO(s) and hospitals (or their associations) cannot be secured in a timely fashion, the State should indicate that adequate time for review and comment was provided these organizations. The SRS Regional Office should acknowledge receipt of the State monitoring plan within 10 days. If the single State agency has not received acknowledgement within 10 days, it should follow up to assure that the plan has in fact been received.

The SRS Regional Office, after appropriate consultation with staff of PHS should be able to render a decision regarding the adequacy of the plan within 45 days of receipt. If the single State agency has not received a reply within that time period, follow up with the Regional Office should be made.

Problem Referral

In addition to the information accumulated through structured monitoring of the impact of review on the Medicaid program, it is likely that the State will, from time to time, become aware of present or potential PSRO procedural problems. These are problems relevant to the efficiency of PSRO performance, e.g., timeliness of reviews, notices to recipients, etc. These problems should be referred to the SRS Regional Office, which in turn will pass them on to PHS, which has primary responsibility for the review and evaluation of internal PSRO operations.

Monitoring Methods and Data

As the PSRO successfully moves from conditional to "fully operational" status, the State may continue to monitor, at its option, but it is expected that increased State confidence in PSRO performance will result in less expensive, resources-intensive monitoring. During this phase State monitoring is expected to rely more heavily on the review of performance using aggregate statistics, with more intensive methods, such as case-by-case monitoring, reserved for suspected or identified problem areas. Information resulting from Departmental monitoring will also be available to States.

If the State elects to conduct case-by-case monitoring requiring hospital medical records and other information available to the PSRO when making review decisions, the State may obtain these from the PSRO if the State needs are very limited. If the State needs a substantial number of records, arrangements should be made directly with the hospitals. PSRO data and information may be disclosed to the State within the limitations set forth in Departmental confidentiality policy.

In addition to information from the Department and from State monitoring, the State may have historical information appropriate for analyzing differences between PSRO decisions and those made under State review mechanisms. Care must be taken to assure that comparative differences are due to PSRO review and not to extraneous factors such as changes in benefits, eligibility or patient mix.

Summary

States have the option of actively monitoring PSRO review determinations utilizing information available from the Department and from PSROs as well as from State sources. State monitoring should be designed to supplement and complement the monitoring conducted by the Department. Due to the cost involved, intensive State monitoring should be limited to the conditional phase of PSRO development unless a special problem requiring indepth examination is identified.

COMPLAINT SYSTEM

To provide a system for seeking resolution of State concerns identified by the monitoring of PSRO review decisions during the conditional period, five steps have been developed and are suggested to States as the best method for obtaining expeditious review by the Department of their concerns. Initially the State and the PSRO should try to resolve problems identified by the State indicating noncompliance by the PSRO with review procedures required by the Secretary. If the parties are unable to do this the State should report the noncompliance directly to the SRS Regional Commissioner for corrective action.

Formal complaints by States should be based on evidence of a State fiscal problem directly resulting from PSRO review determinations or on indications that PSRO review decisions are adversely affecting the quality of care given to Medicaid patients. Evidence could consist of increased payments clearly due to the PSRO review system, or documentation indicating inappropriate determinations regarding necessity and/or quality of certain care or services rendered to Title XIX patients.

Ordinarily, most concerns will be resolved within steps 1 and 2 of the suggested approach below, as a result of an ongoing working relationship between the State and the PSRO. However, if a conditional PSRO is not responsive to particular State concerns of a serious nature, the State may wish to proceed immediately to step 3.

Step 1. State monitoring should provide ongoing informal feedback to PSROs and the State should bring questionable determinations to the attention of the PSRO for discussion and resolution. This interchange can be especially valuable to PSROs during the early stages of implementing review.

Step 2. There should be formal feedback at periodic intervals on a continuing basis from the State to the PSRO and the Department. Provision for periodic meetings to resolve problems should be a standard element in State/PSRO administrative procedures.

Step 3. Where a State finds that a serious problem appears to exist in the overall appropriateness of PSRO review decisions, the State should seek resolution of the problem by notifying the conditional PSRO and requesting corrective action. The PSRO shall respond to the State request within 30 days. If necessary, a meeting between the PSRO and the State to resolve the matter should be scheduled. At the same time the State notifies the PSRO, the State should also notify the SRS Regional Commissioner of the problem, supported by findings, and then notify him of the results of the meeting.

Since any serious problem is likely to involve disagreements between the State and the PSRO regarding medical necessity and/or quality of care, the parties may seek impartial professional assistance in settling the dispute. Within the 30 day response period, the State and PSRO may, at their option, arrange for a group of knowledgeable physicians, acceptable

to both the PSRO and the State agency, to review the questioned determinations and the bases utilized in making the determinations. The composition of such groups should be previously specified in the PSRO/State administrative procedures. The physician group will advise the parties within the 30-day period of the results of its review, and specifically as to whether, considering the State's assessment, the questioned PSRO determinations were based upon professionally accepted judgments of medical practice. If this advice is accepted by the PSRO and the State, the State should notify the SRS Regional Commissioner of the resolution of the problem.

Step 4. If the activities in Step 3 are unsuccessful and the State regards the problems as having serious impact upon the administration of the State Medicaid program, the State official responsible for the Medicaid program or a higher official of the State, should file a written complaint with the SRS Regional Commissioner accompanied by the PSRO response and the physician group report, if applicable. A copy of the complaint should also be submitted to the Regional Health Administrator and the PSRO. The complaint should: (1) state the problem, (2) specify the State's findings; (3) discuss attempts, if any, at resolving the matter with the PSRO; and (4) based upon the State's judgment as to the seriousness of the problem, request the Department to: (a) work with concerned parties to correct the problem, or (b) temporarily suspend the PSRO's authority to make conclusive determinations.

If the State does not consider the problem serious enough to request suspension of the PSRO's authority to make conclusive determinations, then the Department will formulate a plan and take corrective action within 90 days.

If the State views the problem as serious enough to request such temporary suspension, it is most important that the complaint contain the documentation specified below and copies of communications between the State and PSRO as described in Step 3. The Department will promptly suspend the PSRO's conclusive review authority prior to an extensive, independent Federal assessment if the Department finds that the documentation reasonably supports the State's concern. Any such suspension shall remain in effect until the Department has determined that the PSRO should resume responsibility for review decisions. Immediate suspension of the PSRO's conclusive review authority prior to extensive independent Federal assessment is an emergency action which should not be recommended by the State unless the necessity for such action is demonstrated.

For thorough Departmental consideration, complaints should be accompanied by documentation specifying (1) the alleged improper review determinations of the PSRO, (2) detrimental impact on State Medicaid expenditures and/or the quality of care received by title XIX patients and (3) the correlation between (1) and (2), including indications that factors other than PSRO review which may have contributed to the problem have been examined and eliminated. The Department shall review the complaint

within 30 days of receipt and, if it finds the accompanying documentation reasonable, it will promptly suspend the binding review authority of the PSRO pending a full investigation. The PSRO review system will remain in place and functioning, but PSRO determinations will be advisory to the State during the time of suspension.

It should be noted that the Department has the authority to suspend the PSRO's authority and place the PSRO on advisory status only during the conditional period. Once the PSRO is in fully operational status, termination is the only recourse available to the Department following determination of unsatisfactory performance, pursuant to Section 1152(d) of the Act. The operational PSRO may request and receive a formal hearing prior to such determination.

Step 5. After suspension of the conditional PSRO's conclusive review authority at the request of the State, the Department will conduct an independent assessment of the problem. The Department will utilize a team of expert physicians and others for this purpose which may include, but is not limited to, representatives and designees from the National PSR Council, the Statewide PSR Council if there is one, the State agency, and the Department. If the Department finds that the conditional PSRO is not performing in a satisfactory manner the duties and functions the PSRO was initially found capable of performing upon designation, then the Department may:

(1) place restrictions upon the PSRO's exercise of full review responsibility or the performance of certain duties and functions, including revision of the PSRO's phase-in timetable;

(2) require the PSRO to take corrective action, including the acceptance of technical assistance to improve its performance;

(3) continue the full or partial suspension of the authority of the PSRO to make conclusive determinations for a period of time during which the PSRO's determinations shall be only advisory to the State until the PSRO can demonstrate that corrective measures have been taken; and

(4) terminate the agreement with the PSRO upon 90 days' notice to the PSRO, pursuant to Section 1154(c) of the Act.

APPENDIX B

SRS AT 76-141

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

INTERPRETATION

PLAN PREPRINT

ACTION TRANSMITTAL
SRS-AT-76-141(MSA)
September 3, 1976

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT: Relationship of PSRO Review Responsibilities to the Medicaid Program - Financial Penalties under Section 1903(g)(1) of the Social Security Act and Federal Financial Participation.

REGULATION REFERENCE: 45 CFR 250.20.

RELATED ISSUANCE: SRS-AT-75-42(MSA), dated June 25, 1975: Relationship of PSRO Review Responsibilities to the Medicaid Program.

ATTACHMENTS:

1. Interpretation of effect on State responsibility and liability and on Federal financial participation.

2. Revised pages 1 and 2 of the Title XIX preprinted State plan. The revision reflects that the provisions of Title XI, Part B of the Social Security Act are applicable to State plans, that States are bound by final PSRO decisions made with respect to Medicaid recipients, and that they are not held responsible under the plan for functions for which final authority has been given to PSROs.

ACTION REQUIRED: Submit the revised preprinted pages to the SRS Regional Commissioner by December 3, 1976.

INQUIRIES TO: SRS Regional Commissioners

Commissioner
Medical Services Administration

INTERPRETATION: Impact of PSRO Assumption of Review Responsibility on State Agency Responsibility and Liability; and on Federal Financial Participation

BACKGROUND:

SRS-AT-75-42(MSA) informed all Medicaid single State agencies that, as a result of the Secretary's decisions of February 24, 1975:

1. Conditional PSROs found competent would exercise final authority on issues of medical necessity, quality and appropriateness of care for purposes of claims payment in the Medicaid program;

2. An initial finding of PSRO competency would be made upon conditional designation of the PSRO, and would be subject to reappraisal during the conditional period; and

3. The review systems implemented by conditionally designated PSROs would be accepted by the Department and by Medicaid State agencies as meeting the utilization review requirements imposed by title XIX for those facilities for which the PSRO had assumed review functions. (Section 1164 of the Act makes the PSRO requirements of title XI, Part B, applicable to the operation of State plans involving payment for health care services.)

AT-75-42 also specified that:

1. Although a Memorandum of Understanding (MOU) between the single State agency and the conditional PSRO is not a prerequisite for the assumption of review responsibility by PSROs, it is expected that such parties will enter into such an agreement in good faith in order to facilitate working relationships (the Regional Offices will provide any needed assistance in helping States and PSROs to develop such agreements); and

2. The Secretary's decisions would be implemented by regulations which would provide, in part, for relieving States of responsibility and liability for those utilization review functions for which a PSRO has assumed responsibility.

Because there is some confusion as to whether financial penalties can be imposed under section 1903(g)(1) of the Act in relation to review functions which PSROs have undertaken, and because it may be some time before regulations are published, SRS wishes to make clear to what extent States are relieved of responsibility and liability. Also, the question has arisen about the availability of FFP if a State does not adhere to PSRO medical necessity decisions.

INTERPRETATION:

A. State Relief from Financial Penalties

Specifically, States are relieved from making a satisfactory showing of effective utilization review and from being subject to financial penalty under section 1903(g)(1) for the following functions in those facilities where a PSRO has assumed review responsibility: physician certifications and recertifications (section 1903(g)(1)(A); physician plan of care in short-stay hospitals (section 1903(g)(1)(B); and utilization review (section 1903(g)(1)(C).

The SRS Regional Commissioners will notify States of relief from review responsibility and liability for each facility as binding review authority is assumed by the PSRO .

The Department is currently examining the relationship between PSRO review and the following requirements under section 1903(g)(1): physician plan of care in long-term care institutions, medical review, and independent professional review. States remain responsible for a satisfactory showing with respect to these requirements until instructions are issued which indicate otherwise.

B. Effect on FFP of State Non-adherence to PSRO Medical Necessity Decisions

1. If a State review or monitoring system duplicates the purposes of PSRO review, FFP will not be available for the costs of such State activities.

2. If a PSRO disapproves services as not medically necessary or appropriate and a State nevertheless pays the claim, FFP is not available (except for payment generally authorized by the single State agency for "administrative days"), since section 1158 of the Act prohibits payment of Federal funds where a PSRO has disapproved services. If a PSRO approves services as medically necessary and appropriate and the State denies payment on grounds of lack of medical necessity,

no FFP question arises with respect to the services since the State will not claim any Federal matching. However, in the above instances, a question of substantial compliance with the State plan arises and appropriate HEW action will be taken.

The Department strongly supports the implementation of PSRO review as the mechanism to control unnecessary health care utilization and improve the quality of health care provided Medicaid patients, and we strongly encourage PSROs and State Medicaid agencies to work together closely to help achieve these objectives.

Revision: SRS-AT-76-141 (MSA)
September 3, 1976

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE _____

Citation
45 CFR
Part 201
P.R. 10-9

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the _____ (single State agency)

AT-76-141

_____ submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

45 CFR
205.100
P.R. 10-16

SECTION 1. SINGLE STATE AGENCY ORGANIZATION

1.1 Designation and Authority

(a) The _____

_____ is the single State agency designated to administer or supervise the administration of the medical assistance program under title XIX of the Social Security Act. (All references in this plan to "the State agency" mean the agency named in this paragraph.)

ATTACHMENT 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority whereby it administers or supervises administration of the program.

(b) The State agency which administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965 has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

/ / Yes. The State agency so designated is

_____.
This agency has a separate plan covering

Citation
45 CFR
205.10
P.R. 10-16

AT-76-141

that portion of the State plan under title XIX for which it is responsible.

☐ Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☐ Yes. ATTACHMENT 1.1-B describes these waivers and the approved alternative organizational arrangements.

☐ Not applicable. Waivers are no longer in effect.

☐ Not applicable. No waivers have ever been granted.

(d) ☐ The agency named in paragraph 1.1(a) has responsibility for all determinations of eligibility for medical assistance under this plan.

☐ Determinations of eligibility for medical assistance under this plan are made by the agency(ies) specified in ATTACHMENT 2.2-A. There is a written agreement between the State agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

(e) All other provisions of this plan are administered by the single State agency except for those functions for which final authority has been granted by the Department of HEW to a Professional Standards Review Organization pursuant to title XI of the Act.

(f) All other requirements of 45 CFR 205.100 are met.

APPENDIX C

MSA AT 77-43

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
WASHINGTON, D. C. 20201

PROGRAM INSTRUCTION

ACTION TRANSMITTAL
AT-77- 43 (MSA)
April 15, 1977

TO: STATE AGENCIES ADMINISTERING MEDICAL ASSISTANCE PROGRAMS

SUBJECT: Title XIX Social Security Act - Elements for Assessment of State Plans for Monitoring Conditional PSROs

ATTACHMENT: Explanation of the items which will be used to assess the acceptability of a single State agency plan to monitor the performance of conditional PSROs.

RELATED ISSUANCE: SRS-AT-76-140, September 3, 1976

ACTION REQUIRED: States must observe these elements in preparing monitoring plans.

INQUIRIES TO: Regional Commissioners

for Commissioner
Medical Services Administration

Elements for Assessment of State Plans for Monitoring Conditional PSROs

A. The sSa must provide a detailed description of monitoring techniques to be used. Any one or a combination of the three general types of PSRO monitoring will be accepted, as well as other techniques provided the conditions stated in paragraph A. 4 below are met.

1. Concurrent Review

-State must not totally duplicate concurrent review process of PSRO. The cases selected by the State should be only those in which the PSRO has made a review decision. The State may only re-review cases in the hospital during the conditional phase on a 100% basis for a very limited period of time; or it may conduct such review on a sample basis not to exceed 20%. After the PSRO has been designated fully qualified, this type of monitoring should be discontinued unless a serious problem is detected through retrospective monitoring.

-State may make on-site visits to hospitals to view the concurrent review process.

2. Retrospective review on a case-by-case basis

-State may review a sample of cases retrospectively, using utilization review techniques in place prior to PSRO implementation and compare these results with PSRO decisions. To control duplicative expenditures, this comparative review should be limited to about a 20% or smaller sample and should not continue beyond one year (or the end of the PSROs conditional phase) unless an analysis of the results indicates a need for continued retrospective review.

3. Trend Analysis

-States may compare summary statistics on the patterns of practice of physicians and institutions, on utilization (such as LOS and admission rates) or on review determinations. These statistics may be analyzed in relationship to impact on State expenditures.

-States may compare summary statistics acquired prior to PSRO implementation with statistics available after PSRO implementation or States may use these statistics to observe the performance of a PSRO over time.

4. In addition to the three types of monitoring listed above States may use other monitoring techniques as long as they do not totally duplicate the PSRO concurrent review process or the other responsibilities which the PSRO has.

B. Other factors important to a sSa design for monitoring PSROs are enumerated below.

1. State monitoring techniques should not be designed to duplicate the decisions made by individual PSRO review personnel. It is the responsibility of the PSRO to supervise or monitor individual PSRO personnel. The State's concern should be that the review decisions do not negatively impact on expenditures or quality of care given to title XIX patients.

2. The plan should identify the types and sources of information to be used in monitoring. Procedures for acquiring data from other than State sources should be included.

3. The plan should contain specific analysis techniques. Report formats, ranges of acceptability and similar analysis tools should be included.

4. Comments from hospitals and PSROs must be included with the plan. Documentation of a request for comment with at least a 30-day comment period and a statement from the State that no comments were forthcoming, are acceptable in lieu of comments.

5. The plan should not duplicate the monitoring process which the Bureau of Quality Assurance will use to evaluate PSROs.

   A. The State may request copies of the PMIS reports sent by PSROs to BQA and thereby use the same information.

   B. The State may accompany Federal personnel on assessment site visits.

6. In accordance with the provisions of AT-76-140, the plan should recognize that all problems identified are to be discussed with the PSRO and resolution sought prior to reporting to the SRS Regional Office or filing a complaint.

7. The plan should contain an estimate of the resources required to carry it out, including monitoring and analysis personnel and other necessary direct costs.

APPENDIX D

BQA General Memorandum 15-77

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
BUREAU OF QUALITY ASSURANCE

TO : Planning and Conditional PSROs and Support Center Organizations; Statewide Councils; PHS Regional PSRC Project Officers

DATE: MAY 13 1977

GENERAL MEMORANDUM NO. 15-77

FROM : Director

SUBJECT: DHEW Involvement in the Evaluation of Single State Agency (sSa) Plans to Monitor PSROs

The purpose of this General Memorandum is to describe the role of the Department of Health, Education and Welfare (DHEW) in the review and approval of single State agency plans to monitor PSROs. The plans are to be submitted to the Regional Commissioner of the Social and Rehabilitation Service (SRS) for approval. Prior to submittal, Professional Standards Review Organizations (PSROs) and hospitals will have an opportunity to comment on the plan. PSROs and hospitals should provide comments in a timely fashion and should, at a minimum, indicate any administrative problem anticipated if the plan is implemented. These comments will be forwarded with the plan.

Although the SRS Regional Commissioner has the ultimate responsibility for plan approval, other components of DHEW will be actively involved in plan review. Comments from the other components will assist the Regional Commissioner in making a decision on the acceptability of the plan.

The SRS-Action Transmittal-76-140 allots a 45-day period for plan review and response. The following procedures have been developed to assure a thorough plan review during this time period. Guidelines to be used in evaluating the plan are appended to this General Memorandum.

In accordance with the SRS-AT-76-140 issued on September 3, 1976, State monitoring plans should be submitted initially to the SRS Regional Commissioner. Comments from affected PSROs and hospitals (or hospital associations representing member hospitals) should accompany each monitoring plan submitted. After the Medical Services Administration (MSA) component of the SRS Regional Office (SRS/RO) receives a State monitoring plan, the steps listed below should be followed in order to ensure that the Division of Quality Standards Regional Office (DQS/RO) and Bureau of Quality Assurance Central Office (BQA/CO) each have an opportunity to review all pertinent materials. The SRS/RO will forward the plan to appropriate Central Office components of the Medicaid Program.

Once the SRS/RO receives the sSa monitoring plan and forwards copies of the plan and related comments to DQS/RO, DQS/RO should:

(A) Immediately forward three copies of the plan and comments to the appropriate desk officer, BQA, Division of Program Operations, Rockville, Maryland 20857; and

(B) Review each plan against the appropriate guidelines and other information available concerning PSRO and sSa activities in the specific State.

In order to coordinate the review of the State plan, DQS/RO should forward its comments (indicating areas where the plan requires revisions and what the recommended changes should be) by telephone or telex (and later in writing) to BQA no later than 10 working days after receiving the plan from SRS/RO. BQA will review the monitoring plan, discuss problems with DQS/RO, and in conjunction with Regional Office comments, formally indicate its acceptance or nonacceptance of the plan to DQS/RO within 10 working days of BQA receipt of the plan. DQS/RO should then immediately prepare a memorandum for the Regional Health Administrator (RHA)[1] formally indicating approval or disapproval of the plan to be forwarded to the SRS Regional Commissioner.

If BQA and DQS find the State plan acceptable, the RHA should notify the Regional Commissioner of the acceptability of the plan. BQA/CO will forward any comments on the plan to MSA/CO.

However, if BQA and DQS find the plan unacceptable, the RHA should so indicate in writing to the Regional Commissioner. BQA/CO will be responsible for forwarding comments and recommendations for modifications to MSA/CO. MSA/CO will contact the SRS/RO to express concern about the acceptability of the plan and work with BQA to develop joint recommendations for revisions which will make the plan acceptable. These recommendations will be forwarded by MSA/CO to the SRS/RO. During the period of issue resolution, the SRS/RO will notify the sSa that the plan is under review and recommendations for changes will be forwarded shortly. The SRS Action Transmittal 76-140 requires that the sSa be notified of the status of its monitoring plan no later than 45 days after SRS/RO receives the plan.

1/ Subject to change as DHEW reorganization is implemented

To summarize the process:

(1) If the SRS Regional Commissioner, in conjunction with comments received from MSA/CO, agrees with the BQA finding of unacceptability, the sSa will be notified by the Regional Commissioner that the plan is not acceptable, and must be resubmitted prior to implementation of the State's monitoring of PSROs.

(2) On the other hand, if the SRS Regional Commissioner disagrees with the PHS decisions concerning the State monitoring plan, then the final decision to approve the plan will be made by MSA/CO after consultation with BQA/CO.

DQS/RO should establish and maintain a working relationship with the staff in the Office of the Regional Commissioner. This will facilitate review of the plan and issue resolution at the Regional Office in the time frame allotted (i.e., within the 45-day limit). If a State monitoring plan has been disapproved and must be resubmitted, DQS/RO should request that SRS/RO provide a copy of the resubmitted plan to DQS/RO. DQS/RO should examine the plan to ensure that the recommended revisions are included. If DQS/RO requires assistance in resolving problems with the modified plan, it should contact BQA/CO immediately. The procedures for approving the revised monitoring plan should be followed in the manner described above. Following final approval or disapproval of the plan, DQS/RO will notify PSROs in their area of the MSA/SRS decision.

Finally, the procedures and principal components involved in the review of State plans to monitor PSROs are subject to change as the Health Care Financing Administration becomes fully operational. However, because of the interest in State monitoring of PSRO performance and the fact that both Medicaid State agencies and SRS Regional Commissioners have already been notified of the procedures and guidelines, the Bureau of Quality Assurance is also making available the same information. You will be notified of any changes in the procedures and criteria should they be modified.

Michael J. Goran, M.D.

Attachment

APPENDIX

Guidelines for the Assessment of State Monitoring Plans

A. Monitoring Procedures

Monitoring plans should not go beyond the scope of State monitoring as outlined in SRS-76-140 and must not duplicate Federal monitoring processes. The State may request copies of the PMIS reports sent to BQA. Aspects of a plan applicable to the management of the Medicaid program are inappropriate for inclusion in a plan to monitor PSRO performance. In addition, State monitoring should not be involved in routinely assessing the PSRO review process or PSRO administrative/management practices. Should the State become aware of problems with the review process or the PSRO management practices, the State should refer these problems to the SRS Regional Office for further discussion with the PHS staff. The monitoring techniques listed below may be employed by single State agencies:

1. On-site monitoring

a. As stated in the SRS-AT-76-140, on-site monitoring of PSRO review should be limited to activities which do not duplicate the intent and purpose of the PSRO concurrent review process. In addition, on-site monitoring should not parallel the PSRO review process by extending beyond a trial period (usually one year) during which time the State is carefully assessing PSRO determinations. The plan should specify the types of on-site review, the data to be collected, how comparisons will be made with PSRO determinations, the time frame and frequency of on-site monitoring.

b. States may conduct review of PSRO determinations in the hospital, so long as such review is performed after the PSRO has made its final review determination.

c. States may conduct review in the hospital following PSRO review on 100 percent of the cases for a limited period of time; or States may perform, for more extensive periods of time during the PSRO conditional phase, such review on a sample basis not to exceed 20 percent. After the PSRO has been designated fully qualified this type of monitoring should be discontinued unless a serious problem is detected through retrospective review or data analysis. States may continue to make on-site visits to hospitals to observe the PSRO concurrent review process but not to review cases on a concurrent basis.

2. Retrospective Review on a Case-by-Case Basis

States may review a defined sample of cases retrospectively, using utilization review techniques in place prior to PSRO implementation and compare these results with PSRO decisions. To control duplica-

tive expenditures, this comparative review should be limited to a 20 percent or smaller sample and should not continue beyond one year (or the end of the PSROs conditional phase) unless an analysis of the results indicates a need for continued retrospective review. This type of retrospective review is similar to fiscal intermediary monitoring. The need for continued retrospective review should be documented and approved via the same procedures in which the original State monitoring plan is approved.

3. Trend Analysis

a. States may compare statistics on the patterns of practice of physicians and institutions, as well as on utilization parameters (such as LOS and admission rates), or on review determinations using data from the UHDDS and the certification information provided by the PSRO. The plan should indicate how these statistics will be analyzed in relationship to impact on State expenditures.

b. States may compare statistics acquired prior to PSRO implementation with statistics available from the State after PSRO implementation or States may use these statistics to observe the performance of a PSRO over time. Any protocol developed by the State to compare differences in utilization rates or Medicaid expenditures before and after PSRO implementation must show evidence that potential confounding variables such as changes in benefits, eligibility criteria, patient mix etc., are adequately controlled.

4. Alternate Monitoring Techniques

In addition to the three types of monitoring listed above, States may use other monitoring techniques as long as they do not duplicate the PSRO concurrent review process or other responsibilities of the PSRO such as MCE studies. The State should request action through the Regional Commissioner if they detect problems with the concurrent review process or problems appropriate for MCE studies.

B. Requests for PSRO Data

State requests for PSRO data should be:

(1) designed for monitoring PSRO review determinations and not for tracking or evaluating decisions made by individual review personnel. It is the responsibility of the PSRO to supervise or monitor individual PSRO personnel. These data include the UHDDS and information for certification;

(2) in accordance with BQA confidentiality policies; and

(3) limited to data the PSRO is collecting for review purposes; any requests for data which the PSRO is not collecting may be furnished to the State if the State wishes to contract with the PSRO to collect and provide such data.

If the State has a need for additional data or special reports on an ad hoc basis, the monitoring plan should state that such requests be referred to BQA when the PSRO is unable to furnish them or the PSRO questions the appropriateness of providing the data. Examples of routinely requested report formats should be included in the plan.

C. Additional Plan Elements

(1) The plan should identify the types and sources of information to be used in monitoring. Procedures for acquiring data from sources other than from the State sources should be included. The State may request copies of the PMIS reports and use the information for State monitoring. In addition, the State may accompany Federal personnel on site visits.

(2) The plan should contain specific analysis techniques. Ranges of acceptability and similar analysis tools should be included.

(3) The plan should describe (a) how the difference between the State and the PSRO determinations will be jointly reviewed in order to verify if, in fact, real differences exist, and (b) how the State will identify aspects of the PSRO Program that negatively impact on the quality of care rendered to Medicaid patients and on State expenditures.

(4) In accordance with the provisions of AT-76-140, the plan should recognize that all problems identified are to be discussed with the PSRO and resolution sought prior to reporting to the SRS Regional Office or filing a complaint.

(5) The plan should contain an estimate of the resources required to carry it out, including monitoring and analysis personnel and other necessary direct costs.

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